		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035006

Facility Name: St Patrick's Residence

Address: 1400 Brookdale Rd (Number) Naperville (City) 60563 (Zip Code)

County: DuPage

Telephone Number: 630 416-6565 **Fax #** 630 416-1364

IDPA ID Number: 36-2527011 001

Date of Initial License for Current Owners: 03/07/1965

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501(c)(3)		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Robert A. Gancarz **Telephone Number:** 630 416-6565 X502

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) 04/30/2001 (Date)
(Type or Print Name) Sister Anthony Veilleux
(Title) Administrator

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	42	Skilled (SNF)	42	15,372	1
2		Skilled Pediatric (SNF/PED)			2
3	136	Intermediate (ICF)	136	49,776	3
4		Intermediate/DD			4
5	32	Sheltered Care (SC)	32	11,712	5
6		ICF/DD 16 or Less			6
7	210	TOTALS	210	76,860	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,032	11,356	1,433	13,821	8
9	SNF/PED					9
10	ICF	32,232	18,074		50,306	10
11	ICF/DD					11
12	SC	6,004	5,522		11,526	12
13	DD 16 OR LESS					13
14	TOTALS	39,268	34,952	1,433	75,653	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.43%

D. How many bed-hold days during this year were paid by Public Aid?
187 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/22/1989

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/22/1989 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 1,433

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/2000 Fiscal Year: 12/2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	589,934	61,309		651,243		651,243	(27,331)	623,912			1
2	Food Purchase		515,344		515,344		515,344	(6,815)	508,529			2
3	Housekeeping	425,093	33,194		458,287		458,287	(21,933)	436,354			3
4	Laundry	230,717	23,364	1,931	256,012		256,012	(12,221)	243,791			4
5	Heat and Other Utilities			221,046	221,046		221,046	(10,118)	210,928			5
6	Maintenance	209,252	33,150	35,496	277,898		277,898	17,051	294,949			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,454,996	666,361	258,473	2,379,830		2,379,830	(61,367)	2,318,463			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,459,676	201,938	1,794,606	4,456,220		4,456,220		4,456,220			10
10a	Therapy	105,477	8,992		114,469		114,469		114,469			10a
11	Activities	197,534	2,615	2,160	202,309		202,309		202,309			11
12	Social Services	171,320			171,320		171,320		171,320			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,934,007	213,545	1,814,766	4,962,318		4,962,318		4,962,318			16
	C. General Administration											
17	Administrative	232,618		1,982	234,600		234,600	(1,982)	232,618			17
18	Directors Fees											18
19	Professional Services			84,231	84,231		84,231		84,231			19
20	Dues, Fees, Subscriptions & Promotions			94,931	94,931		94,931	(2,361)	92,570			20
21	Clerical & General Office Expenses	223,882	46,975	98,700	369,557		369,557	(40,561)	328,996			21
22	Employee Benefits & Payroll Taxes			820,546	820,546		820,546	(11,668)	808,878			22
23	Inservice Training & Education			3,129	3,129		3,129		3,129			23
24	Travel and Seminar			5,421	5,421		5,421	(5,421)				24
25	Other Admin. Staff Transportation			1,949	1,949		1,949		1,949			25
26	Insurance-Prop.Liab.Malpractice			67,902	67,902		67,902	(4,184)	63,718			26
27	Other (specify):*											27
28	**TOTAL General Administration**	456,500	46,975	1,178,791	1,682,266		1,682,266	(66,177)	1,616,089			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,845,503	926,881	3,252,030	9,024,414		9,024,414	(127,544)	8,896,870			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St Patrick's Residence #0035006 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			508,208	508,208		508,208		508,208			30
31	Amortization of Pre-Op. & Org.			7,667	7,667		7,667		7,667			31
32	Interest			367,624	367,624		367,624	(142,194)	225,430			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			883,499	883,499		883,499	(142,194)	741,305			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		341,148	98,397	439,545		439,545		439,545			39
40	Barber and Beauty Shops	51,230	1,459	4,001	56,690		56,690	(61,863)	(5,173)			40
41	Coffee and Gift Shops		33,628		33,628		33,628	(31,671)	1,957			41
42	Provider Participation Fee			98,256	98,256		98,256		98,256			42
43	Other (specify):*	63,606		89,783	153,389		153,389	(153,389)				43
44	**TOTAL Special Cost Centers**	114,836	376,235	290,437	781,508		781,508	(246,923)	534,585			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,960,339	1,303,116	4,425,966	10,689,421		10,689,421	(516,661)	10,172,760			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(142,194)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,982)	17		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(21,502)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(273,764)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (439,442)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(77,219)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (77,219)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (516,661)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

St Patrick's Residence

ID# 0035006

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Investment Expense	$ (15,000)	21	1
2	Development Salary	(63,606)	43	2
3	Development Expense	(46,610)	43	3
4	Fund Raising Expense	(41,107)	43	4
5	Barber & Beauty Income	(61,863)	40	5
6	Coffee & Gift Shop Income	(31,671)	41	6
7	Stamp Income	(1,309)	21	7
8	Newspaper Income	(213)	21	8
9	Happy Hour Expense	(2,537)	21	9
10	Public Relations	(2,066)	43	10
11	Undocumented Travel & Seminar Expense	(5,421)	24	11
12	Promotional Advertising	(2,361)	20	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(273,764)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Patrick's Residence # 0035006 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	(27,331)	0	0	0	0	0	0	0	0	0	(27,331)	1
2	Food Purchase	0	(6,815)	0	0	0	0	0	0	0	0	0	(6,815)	2
3	Housekeeping	0	(21,933)	0	0	0	0	0	0	0	0	0	(21,933)	3
4	Laundry	0	(12,221)	0	0	0	0	0	0	0	0	0	(12,221)	4
5	Heat and Other Utilities	0	(10,118)	0	0	0	0	0	0	0	0	0	(10,118)	5
6	Maintenance	0	17,051	0	0	0	0	0	0	0	0	0	17,051	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	(61,367)	0	0	0	0	0	0	0	0	0	(61,367)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(1,982)	0	0	0	0	0	0	0	0	0	0	(1,982)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,361)	0	0	0	0	0	0	0	0	0	0	(2,361)	20
21	Clerical & General Office Expenses	(40,561)	0	0	0	0	0	0	0	0	0	0	(40,561)	21
22	Employee Benefits & Payroll Taxes	0	(11,668)	0	0	0	0	0	0	0	0	0	(11,668)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(5,421)	0	0	0	0	0	0	0	0	0	0	(5,421)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	(4,184)	0	0	0	0	0	0	0	0	0	(4,184)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(50,325)	(15,852)	0	0	0	0	0	0	0	0	0	(66,177)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(50,325)	(77,219)	0	0	0	0	0	0	0	0	0	(127,544)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Patrick's Residence # 0035006 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(142,194)	0	0	0	0	0	0	0	0	0	0	(142,194)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(142,194)	0	0	0	0	0	0	0	0	0	0	(142,194)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(61,863)	0	0	0	0	0	0	0	0	0	0	(61,863)	40
41	Coffee and Gift Shops	(31,671)	0	0	0	0	0	0	0	0	0	0	(31,671)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(153,389)	0	0	0	0	0	0	0	0	0	0	(153,389)	43
44	**TOTAL Special Cost Centers**	(246,923)	0	0	0	0	0	0	0	0	0	0	(246,923)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(439,442)	(77,219)	0	0	0	0	0	0	0	0	0	(516,661)	45

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Carmelite Sisters	100.00	None		Carmelite System	Germantown	Religious Order

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$ 27,331	Carmelie Sisters Convent		$	$ (27,331)	1
2	V	2	Food Purchase	27,059	Carmelie Sisters Convent		20,244	(6,815)	2
3	V	3	Housekeeping	21,933	Carmelie Sisters Convent			(21,933)	3
4	V	4	Laundry	12,221	Carmelie Sisters Convent			(12,221)	4
5	V	5	Utilities	16,874	Carmelie Sisters Convent		6,756	(10,118)	5
6	V	6	Maintenance	26,824	Carmelie Sisters Convent		43,875	17,051	6
7	V	22	Employee Benefits	11,668	Carmelie Sisters Convent			(11,668)	7
8	V	26	Insurance	4,184	Carmelie Sisters Convent			(4,184)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 148,094			$ 70,875	$ * (77,219)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	City of Naperville-Firstar Bank		X	Mortgage		12/19/98	$ 6,820,000	$ 6,168,000	01/01/2013	0.0491	$ 306,689	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Harris Bank		X	Working Capital LOC		01/15/00	785,000		11/30/2000	0.0825	60,935	6
7												7
8												8
9	TOTAL Facility Related						$ 7,605,000	$ 6,168,000			$ 367,624	9
	B. Non-Facility Related*											
10												10
11												11
12	Interest Income											12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 7,605,000	$ 6,168,000			$ 367,624	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 118,218 B. General Construction Type: Exterior CMV Block Frame Pre-Cast Concrete Number of Stories Three

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 116,922
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 7,667
4. Dates Incurred: 1997

Nature of Costs: Bond Issuance Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	7.33 Acres	1987	$ 638,590	1
2					2
3	TOTALS	7		$ 638,590	3

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	210		1989	1989	$ 7,786,645	$ 271,499	40	$ 271,499	$	$ 3,198,235	4
5			1997	1997	2,194,676	54,867	40	54,867		192,034	5
6			2000	2000	2,987,034	18,805	40	18,805		18,805	6
7											7
8											8
	Improvement Type**										
9	Various-Land Improvements			1990	128,000	8,867	15	8,867		102,281	9
10	Various-Land Improvements			1993	22,602	3,585	10	3,585		26,789	10
11	Various-Land Improvements			1994	1,501	75	20	75		492	11
12	Various-Building Improvements			1991	4,862	324	15	324		3,240	12
13	Various-Building Improvements			1993	6,887	665	10	665		4,745	13
14	Various-Building Improvements			1994	30,111	2,597	15	2,597		16,321	14
15											15
16	Beauty Shop Improvements			1996	2,417	242	10	242		1,148	16
17	Business Office Improvements			1996	559	112	5	112		532	17
18	Chapel Landscaping			1997	15,237	762	20	762		2,667	18
19	Chapel Landscaping			1997	14,000	700	20	700		2,450	19
20	Chapel Landscaping			1997	11,363	568	20	568		1,988	20
21	Smoke Alarms			1997	9,000	1,800	5	1,800		6,300	21
22	Carpentry			1997	1,966	393	5	393		1,376	22
23	B Gunther and Co Improvements			1997	1,000	200	5	200		700	23
24	Security System-Magnetic Doors			1998	4,949	494	10	494		1,235	24
25	Replace Mortar-Structural Preservtn			1998	5,744	574	10	574		1,435	25
26	Stained Glass Windows-Robt Harmon			1998	14,500	362	40	362		905	26
27	Landscaping Trees			1998	3,022	152	20	152		377	27
28	Outside Signage-St Joes			1999	3,200	160	10	160		240	28
29	Locking Magnetic Doors-First Security			1999	3,632	363	10	363		545	29
30	Repaved Parking Lot-Paveman			2000	6,838	171	20	171		171	30
31	Outside Awning-Accent Awning Co			2000	2,398	60	20	60		60	31
32	Replace Mortar-Structural Preservtn			2000	7,345	184	20	184		184	32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 13,269,488	$ 368,581		$ 368,581	$	$ 3,585,255	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,799,914	$ 112,837	$ 112,837	$	5 & 10	$ 1,424,590	37
38	Current Year Purchases	201,637	14,866	14,866		5 & 10	14,866	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 2,001,551	$ 127,703	$ 127,703	$		$ 1,439,456	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility Business	1996 Pontiac Van	1996	$ 22,444	$ 5,611	$ 5,611	$	4	$ 22,444	42
43	Facility Business	1994 Ford Bus	1994	39,951	4,001	4,001		10	27,659	43
44	Facility Business	1996 Dodge Pickup	2000	23,116	2,312	2,312		5	2,312	44
45										45
46	TOTALS			$ 85,511	$ 11,924	$ 11,924	$		$ 52,415	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 15,995,140	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 508,208	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 508,208	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 5,077,126	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 9,198	$		$ 9,198	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			8,223			8,223	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			32,249			32,249	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				242,577		242,577	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supprt Schedule					48,727	98,571		147,298	13
14	TOTAL			$		$ 98,397	$ 341,148		$ 439,545	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,969,584	$	1
2	Cash-Patient Deposits	29,063		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 48,000)	861,154		3
4	Supply Inventory (priced at Cost)	35,413		4
5	Short-Term Investments			5
6	Prepaid Insurance	64,027		6
7	Other Prepaid Expenses	9,553		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,968,794	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	638,590		13
14	Buildings, at Historical Cost	13,066,915		14
15	Leasehold Improvements, at Historical Cost	202,563		15
16	Equipment, at Historical Cost	2,087,062		16
17	Accumulated Depreciation (book methods)	(5,077,129)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Bond Issuance Costs	93,340		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,011,341	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,980,135	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 372,322	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,063		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	391,539		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,764		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	153,402		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	73,809		36
37	Medicare Settlement	4,791		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,026,690	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	6,168,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,168,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,194,690	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,785,445	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,980,135	$	48

***(See instructions.)**

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,615,382	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,615,382	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	54,148	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	115,915	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 170,063	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 7,785,445	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,134,302	1
2	Discounts and Allowances for all Levels	(2,364,855)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,769,447	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	200,651	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 200,651	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	31,671	12
13	Barber and Beauty Care	61,863	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	23,519	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	70,262	19
20	Radiology and X-Ray	118,834	20
21	Other Medical Services	43,728	21
22	Laundry	2,834	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 352,711	23
	D. Non-Operating Revenue		
24	Contributions	305,094	24
25	Interest and Other Investment Income***	142,194	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 447,288	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Gain/(loss) on Investments**	(28,898)	28
28a	**Vending Machine**	2,370	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (26,528)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,743,569	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,379,830	31
32	Health Care	4,962,318	32
33	General Administration	1,682,266	33
	B. Capital Expense		
34	Ownership	883,499	34
	C. Ancillary Expense		
35	Special Cost Centers	683,252	35
36	Provider Participation Fee	98,256	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,689,421	40
41	**Income before Income Taxes (line 30 minus line 40)****	54,148	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 54,148	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,211	2,387	$ 56,942	$ 23.86	1
2	Assistant Director of Nursing	2,316	2,596	50,976	19.64	2
3	Registered Nurses	26,850	29,318	556,766	18.99	3
4	Licensed Practical Nurses	26,672	29,066	526,255	18.11	4
5	Nurse Aides & Orderlies	90,622	97,693	1,203,565	12.32	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,894	2,254	49,560	21.99	7
8	Rehab/Therapy Aides	3,973	4,713	55,917	11.86	8
9	Activity Director	1,055	1,787	38,971	21.81	9
10	Activity Assistants	12,915	14,085	158,563	11.26	10
11	Social Service Workers	8,778	9,778	171,320	17.52	11
12	Dietician	1,507	1,675	46,622	27.83	12
13	Food Service Supervisor	3,792	4,362	61,827	14.17	13
14	Head Cook	3,968	4,457	66,904	15.01	14
15	Cook Helpers/Assistants	47,227	51,546	414,581	8.04	15
16	Dishwashers					16
17	Maintenance Workers	15,324	17,052	209,252	12.27	17
18	Housekeepers	42,349	47,508	425,093	8.95	18
19	Laundry	20,676	23,708	230,717	9.73	19
20	Administrator	2,400	2,520	64,293	25.51	20
21	Assistant Administrator	2,400	2,520	55,813	22.15	21
22	Other Administrative	4,281	4,756	112,512	23.66	22
23	Office Manager					23
24	Clerical	18,077	19,990	223,882	11.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	5,228	5,604	65,172	11.63	32
33	Other(specify) Devlpmnt/Beauty	5,585	6,456	114,836	17.79	33
34	TOTAL (lines 1 - 33)	350,100	385,831	$ 4,960,339 *	$ 12.86	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	18,000	9-3	36
37	Medical Records Consultant	96	4,020	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,420	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	1,260	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	112	$ 24,700		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	17,647	$ 697,930	10-3	50
51	Licensed Practical Nurses	2,083	72,908	10-3	51
52	Nurse Aides	55,045	1,018,328	10-3	52
53	TOTAL (lines 50 - 52)	74,775	$ 1,789,166		53

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sister Anthony	Administrator		$ 64,293
Sister Jeanne	Asst Admnstrtr		55,813
Robert Gancarz	Controller		62,164
Kenneth Deardorff	HR Director		50,347
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 232,617

B. Administrative - Other

Description	Amount
Government Fine	$ 1,982
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,982

C. Professional Services

Vendor/Payee	Type	Amount
PriceWaterhouseCoopers	Auditing	$ 23,400
Frost, Ruttenberg & Rothblatt	Medicare/Medicaid Consult	8,273
TTC Illinois	Payroll Process/Consult	6,161
Katten, Muchin & Zavis	Legal	11,591
CHCS	Survey Consulting	17,820
Practical System Solutions	Computer Consulting	9,976
Medinet	Billing	1,400
Method Management	Nurse Consulting	3,000
Margolis Marmel & Crosby	Tax Consulting	2,610
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 84,231

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,354
Unemployment Compensation Insurance	4,300
FICA Taxes	339,882
Employee Health Insurance	273,151
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life & Disability Insurance	34,863
Pension	87,400
Staff Development	7,295
Employee Physicals & Vaccinations	1,301
TOTAL (agree to Schedule V, line 22, col.8)	$ 820,546

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	57,934
Health Care Worker Background Check	1,514
(Indicate # of checks performed 216)	
Association Fees	9,258
Dues And Subscriptions	2,571
Promotional Advertising	2,361
Employee Promotions	16,571
Less: Public Relations Expense	( )
Non-allowable advertising	2,361
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 92,570

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St Patrick's Residence # 0035006 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Netwwork $8,250**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **102,753** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **98,256**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ ____
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **PriceWaterhouseCoopers** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Board of Directors Listing

Bishop Joseph L Imesch

Reverend William E. Donnelly

Sister M. shawn Bernadette Flynn, O. Carm

Sister M. Kevin Patricia Lynch, O. Carm

Sr M. Paul Anthony Videtich, O. Carm

Sr Ann McCartney, O. Carm

Sr Ann Dailey, O. Carm

Sr Mary Rose Heery, O. Carm

Sr Ann Elizabeth Brown, O. Carm

Mr. Carmen S. DiGiovine
Mr. John J. Durso
Mr. Robert D. Gillen
Mr. Raymond E. Jones
Miss Josephine Mancuso
Mr. Ron Santo

Supplemental Schedule of Medical Supplies
Line 13

Special Services-Supplies (column 6-Supplies)		$ Amount
1 Medical Supplies		498
2 X-Ray Services		88,619
3 EKG Services		9,454
Total	39-2	98,571

Outside Therapies (Column 5- Cost)		$ Amount
1 Medicare Part A Therapies		48,727
Total	39-3	48,727